



Request for Physician's Report Questionnaire

Claimant Information:

Last Name: _____ First Name: _____ MI: _____ ID or SSN: _____

(Este es un documento importante. Si usted necesita un intérprete, póngase en contacto con su oficina local.)

A physician's statement is needed in connection with your claim since the health of the claimant is a factor affecting the claimant's eligibility for unemployment insurance benefits.

Action on this claim is being withheld pending receipt of your physician's report (below) which is needed for making a determination as to whether or not the claimant is eligible to receive benefits.

The patient is to complete Section A, B, C and D. The Physician is to complete Section E and F. Please complete, sign and return this questionnaire to the Illinois Department of Employment Security Office as instructed. Failure to respond will result in a determination based on the available information. Before returning the questionnaire, be sure that all requested information is completed.

If you need additional space, please use the other side of this document, if appropriate, or attach a separate sheet of paper.

Section A: Physician Information	Request for Information as of
Physician Name: _____	
Address 1: _____ Address 2: (Apt., Floor, Suite, etc.) _____	
City: _____ State: _____ Zip Code: _____	
Telephone Number: () - _____	
Section B: Authorization to Physician	
Last Name: _____ First Name: _____ MI: _____	
Address 1: _____ Address 2: (Apt., Floor, Suite, etc.) _____	
City: _____ State: _____ Zip Code: _____	
Health ID #: _____ Birth Date: / /	
Spouse/Dependent Name: _____	
You are hereby authorized to furnish the Illinois Department of Employment Security with complete information regarding my physical condition as of _____.	
Section C: Patient Signature	
Patient Signature : _____ Date: / /	
Patient Name : (Printed or Typed) _____	
Section D: Patient's Work	
The patient's customary work has been as:	
Which involves the following general physical demands:	
The patient states that as of _____ his/her work limitations are:	

Section E: Physician's Report

What is or was the nature of the patient's disability as of _____ ?

If patient is pregnant, what is probable date of confinement? _____ / _____ / _____

Is the patient able to use ordinary means of transportation? Yes No

If miscarriage, what was the date? _____ / _____ / _____

If baby was born, what was the date of birth? _____ / _____ / _____

Is patient now able to work full time in his/her customary occupation? Yes No

If No, on what date may patient return to work? _____ / _____ / _____

If Yes, on what date was patient able to return to full-time work? _____ / _____ / _____

If the patient is unable to work full-time in customary occupation what, if any, kind of full-time work is patient able to perform?

Did you advise patient to leave employment on or before _____ ? Yes No

If Yes, on what date? _____ / _____ / _____

If Yes, did you advise the patient to leave work because assistance is necessary for the purpose of caring for his/her spouse, child, or parent who is in poor physical health? Yes No

If Yes, in your opinion would such assistance not allow the patient to perform the usual and customary duties of his/her employment? Yes No

Please give prognosis, in non-technical terms, and remarks here.

Section F: Physician Signature

Physician's Signature: _____ Date: _____ / _____ / _____

Physician's Name (printed)